Pre-HIV antibody testing—too much fuss?

Riva Miller, Robert Bor

Does the apparent mystique surrounding pre-test counselling deter some doctors from talking to patients about an HIV test? Does pre-test counselling sometimes deter people from coming forward for testing? Does pre-test counselling exacerbate difficulties with patient management? We do not have conclusive data to provide answers to any of these questions. Since the HIV antibody test became available in 1985, approaches to diagnosis, treatment and care have shifted, and there are moves towards more widespread HIV testing. It is timely now to reconsider the place and purpose of pre-test counselling. Is there indeed too much fuss being made in providing it?

Information and advice about preparing patients for and obtaining consent to HIV testing were included in the Department of Health[1] (1985) and General Medical Council[2] (1988) guidelines for doctors. As with all tests and investigations doctors are expected to ensure that each patient is fully informed about the procedure and that consent to carrying out a procedure is obtained. The importance of consent to HIV testing was emphasised because of the serious social, personal and financial consequences that may ensue from a positive test result. Pre-test counselling is also the basis from which to take a detailed sex and risk behaviour history from the patient and an opportunity to attempt to minimise transmission of HIV through health education.

The demand for testing

With an increasing demand and need for HIV testing it will not be possible, or perhaps even necessary, to continue to put the same emphasis on pre-test counselling as has been hitherto recommended. Many people who voluntarily opt for testing are now generally more knowledgeable about HIV. Doctors in all clinical settings should consider HIV as part of a differential diagnosis.[3] Screening pregnant women may become more widely accepted as the epidemic spreads into the heterosexual population. Negotiations to lessen the discriminatory effects of life insurance are likely to be more successful if testing becomes a normal part of health screening. The Chief Medical Officer encouraged more widespread testing on World AIDS Day 1990 because of the emerging medical advantages to early diagnosis and the treatment of asymptomatic HIV disease.[4] All these factors indicate that the trend towards more testing can only continue, which will serve to normalise HIV infection similar to other non-curative acute and chronic conditions such as leukaemia, chronic hepatitis and cancer.

The question of who should counsel

The question of who should offer counselling is a delicate one. When the test first became available specialist counsellors were appointed to provide support for people with HIV infection, and to counsel people about the meaning and implications of the HIV test. The Chief Medical Officer, in a keynote address in 1986, discussing public policies on AIDS, said that trained counsellors should be available in all genitourinary clinics to advise patients and their partners for whom a test for HIV is indicated.[5] If more doctors and nurses take on the task of pre-test counselling, some counsellors may question whether this might jeopardise standards of counselling or yield professional territory in this area of medical practice where counselling has been taken more seriously. It may do both. From our practice we have seen that there is a difference between the activity of counselling, which most health care providers undertake in the course of their work, and being a professional counsellor which requires special skills and expertise.[6]

Doctors in their daily practice discuss diagnoses, investigations, treatments and prognoses with patients. Pre-HIV test discussion should form part of this consultation and differential diagnosis process, and not be divorced from routine medical care. In shifting some of the responsibility for pre-test counselling on to doctors provision must be made for specialist counsellors to help with HIV positive patients, or those who, for whatever reason, require specialist counselling support. As in any other clinical situation, doctors, who for any reason are unable or lack the necessary skills or facilities to provide adequate pre-test discussion should refer that patient to a professional colleague such as a specialist counsellor.

The question of what is counselling

The mystique surrounding pre-test counselling is only removed by initiating HIV discussion with patients. The idea that this task is invariably time consuming is unfounded. Most of our pre-test counselling sessions with people who request a test last no more than 10–15 minutes.[7] Too much conversation can interfere with people's ability to make decisions. However, the consequences of inappropriate or insensitive counselling can present later as psychological symptoms or difficulties in patient management. It is ultimately for each clinician to decide whether patients have been fully prepared for testing in the available time. This can be done briefly and succinctly. In counselling the inverse law applies. That is, the briefer the contact with the patient the more skills are required to ensure that people are able to make properly informed decisions for themselves about testing. Some doctors and nurses may wish to enhance and develop their counselling skills in order to use the available time most effectively. One way of acquiring new ideas and skills is to work alongside counselling colleagues with some cases. This also gives counsellors an opportunity to appreciate more fully some of the complex issues that doctors confront.

The question of what approach to counselling is appropriate

Where doctors consider HIV as part of a differential diagnosis or for the purposes of health screening, we suggest that there could be three levels of information-giving and counselling practice. At one level, there are some patients in particular settings where it may be sufficient to provide brief face-to-face discussion, accompanied by printed material or videotape recordings giving information about the test and what follow-up is available. On a second level more detailed discussion is required through taking a medical history to establish a risk or make

a provisional diagnosis prior to testing. A third level of pre-test counselling is where even more detailed, time-consuming discussion is indicated in order to obtain informed consent as part of the diagnostic process. An example of this is when an HIV diagnosis is likely, but general fear and anxiety impedes the patient's decision-making or testing is refused. Consulting or referring the patient to a specialist counsellor may be necessary. With these three levels of pre-test counselling, and the back-up of expert colleagues, the emphasis could then focus on establishing whether or not a person wishes to be tested and if he or she is sufficiently prepared and informed for the result.

Brief counselling approaches can be developed.[8] New approaches to HIV pre-test counselling and the effect they have on decisions about testing will have to be subjected to rigorous assessment. No-one can yet claim that one approach or style is better than another. As people who receive treatment live longer professional counsellors will find increasing pressure to work with those living with HIV disease, their contacts and family. A lengthened lifespan does not necessarily decrease personal distress or anxiety about the future, and some patients may feel more inclined to take risks that could lead to HIV transmission.

Conclusion

The risk of continuing to put emphasis on pre-test counselling as has been done in some settings is that some clinicians may resort to testing with little attention to obtaining informed consent. Or they may be tempted to avoid discussion and testing which would jeopardise the patients' options for optimum medical and psychosocial care. In clinical settings the need and demand for testing must be balanced against available resources. It is not a question of whether doctors or specialist counsellors should provide the pre-test counselling; they need to collaborate in this complex task. Some of the fuss it seems, is over who counsels, and how much is necessary. These are issues which should be settled between professionals in the first instance otherwise patients will become the casualties of gate-keeping posturing. We suggest it is the remit of doctors and some other health care providers to broach the subject of HIV and counsel their patients about testing to a level which will help the majority of patients decide whether to proceed with an HIV test. A separate issue is one of personal confidence and skills to do this.

One must not lose site of the fact that the meaning of an HIV positive test result changes as biomedical advances improve the outlook for those living with HIV disease, and the social and political conditions shift. The emphasis that has been placed on pre-test counselling should not in any way be forgotten. Rather it should remind us that informed consent should be obtained for all tests and procedures in all normal circumstances with all patients.

RIVA MILLER
ROBERT BOR

AIDS Counselling Unit,
Royal Free Hospital,
Hampstead,
NHS Trust and School of Medicine,
London, NW3 2QG, UK

1 Department of Health and Social Security. *AIDS—information for doctors concerning the introduction of the HTLV111 antibody test. London: DHSS,* Oct 1985.
2 General Medical Council. *HIV Infection and AIDS: The Ethical Considerations,* May 1988.
3 Gazzard B. GPs must be on the alert for AIDS at all times. *General Practitioner* 18 October 1985.
4 Acheson, D. Keynote address. 'AIDS: Impact on public policy'. An international forum: policy, politics and AIDS. *Proceedings of the AIDS International Symposium, 28–30 May, New York.* 1986 Hommel R, Leavy W, Rampolla M, Chorost S, eds. New York: London 131–37.
5 Graham N, Scott Z, Lawrence P, *et al.* Effect of zidovudine and *Pneumocystis carinii* pneumonia prophylaxis on progression of HIV-1 infection to AIDS. *Lancet* 1991;**338**:265–9.
6 Miller R, Bor R. *AIDS: A Guide to Clinical Counselling.* 1988 London: Science Press.
7 Squire B, Elford J, Bor R, *et al.* Open access clinic providing HIV-1 antibody results on day of testing: the first twelve months. *BMJ* 1991;**302**:1383–6.
8 Bor R, Miller R, Johnson M. A testing time for doctors: counselling patients before an HIV test. *BMJ* 1991;**303**:905–7.